Queensland Health

Clinical Task Instruction

Skill Shared Task

S-SP01: Screen for mood problems using a standardised tool and provide basic/bridging intervention

VERSION CONTROL

Version:	1.0		
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The CTI reflects best practice and agreed process for conduct of the task at the time of approval and should not be altered. Feedback, including proposed amendments to this published document, should be directed to AHPOQ at: allied_health_advisory@health.qld.gov.au.

This CTI must be used under a skill sharing framework implemented at the work unit level. The framework is available at: https://www.health.qld.gov.au/ahwac/html/calderdale-framework.asp

Please check https://www.health.qld.gov.au/ahwac/html/clintaskinstructions.asp for the latest version of this CTI.

Scope and objectives of clinical task

This CTI will enable the health professional to:

- safely and effectively screen for mood problems using the Depression, Anxiety and Stress Scale-21 (DASS-21) and/or the Geriatric Depression Scale – short form (GDS-15), record and interpret results.
- develop and implement a plan to address identified mood problems including supporting the team's decision-making with regard to safety, providing standard education and referring to other health professionals for comprehensive assessment/review if required.

Note 1: In this CTI, the term 'mood problems' is used to refer to a negative emotional state affecting a client's wellbeing. This CTI does not diagnose or comprehensively assess mood problems. Standardised screening tools are used to assist in determining if symptoms of depression, stress and anxiety are present. This CTI is designed to support the skill share-trained health professional to recognise and appropriately respond to identified mood symptoms, including supporting timely referral for comprehensive psychological assessment.

Note 2: This CTI provides learning resources for the DASS-21 and the GDS-15. Health services may require additional tools for this skill shared task, for example Patient Health Questionnnaire-9 (PHQ-9) or Anxiety and depression checklist (K10). The local health service will determine which standardised tools are included in the scope for the skill shared task. Professionals with expertise in this clinical area and relevant service managers will guide the decision-making on tools included in the scope of the skill shared task implementation. If additional or alternative tool/s are integrated, the training and competency assessment plan for these tools should be recorded on the Performance Criteria Checklist.

Requisite training, knowledge, skills and experience

Training

- Mandatory training requirements relevant to Queensland Health/Hospital and Health Service (HHS) clinical roles are assumed knowledge for this CTI.

Clinical knowledge

- To deliver this clinical task a health professional is required to possess the following theoretical knowledge:
  - the risk factors and prevalence of mood problems in the client cohort in the local service.
  - common presenting features and causes of depression, anxiety and stress. This may include physiological signs and symptoms or common presentations relevant to the client cohort in the local service e.g. financial, emotional, social and physical stressors.
  - the rationale, purpose, benefits and limitations of screening for mood symptoms using standardised tools for depression, anxiety and stress.
  - testing protocol and procedure for the GDS-15 and DASS-21 and any additional tools considered in scope for the local service. This includes indications for use, testing protocol, scoring, interpretation of scores and normative data.

  - common strategies used to manage depression, anxiety and stress including the rationale, limitations and risks associated with each intervention.
- The knowledge requirements will be met by the following activities:
  - review of the Learning Resource.
  - receive instruction from the lead health professional in the training phase.
  - read and discuss the following references/resources with the lead health professional at the commencement of the training phase:
    - local referral pathways and processes for mental health care including psychological assessment.

Skills or experience

- The following skills or experience are not specifically identified in the task procedure but support the safe and effective performance of the task or the efficiency of the training process and are:
  - **required** by a health professional in order to deliver this task:
    - nil.
  - **relevant but not mandatory** for a health professional to possess in order to deliver this task:
    - experience providing standardised screening for cognition, perception and/or memory e.g. CTI S-CP01: Screen for cognitive impairment using a standardised tool and provide basic/bridging intervention.

Indications and limitations for use of a skill shared task

The skill share-trained health professional shall use their independent clinical judgement to determine the situations in which they will deliver this clinical task. The following recommended indications and limitations are provided as a guide to the use of the CTI, but the health professional is responsible for applying clinical reasoning and understanding of the potential risks and benefits of providing the task in each clinical situation.

Indications

- The client reports feelings of stress, anxiety or depression. This may include statements of hopelessness, helplessness, being overwhelmed or not feeling themselves, flat, foggy, down, nervy/fidgety, worried or out of control, or feelings negatively impacting on their quality of life.

OR

- The client (or carer/staff) have described changes in behaviour that could be mood-related, and which may place the client at a potential risk of harm including changes in:
  - sleep patterns, including not sleeping, regularly waking, difficulty getting to sleep or being excessively sleepy.
  - changes in appetite including not eating or excessive eating.
  - lack of enjoyment in usual activities including hobbies.
  - a mood that is incongruent with the situation. This may include a flat affect, tears, excessive irritability or agitation.

  - reports or observation of physical symptoms, including being shaky, trembly, sweaty or pale, that are incongruent with the environment or situation.
  - reports or observation of a lack of initiation and/or motivation, including social withdrawal and isolation or an inability to complete activities of daily living, for example work attendance or self-care (hygiene, personal appearance or nutrition).

OR

- The client requires standardised testing to be undertaken as part of a local standard screening or monitoring protocol to support the decision making of the multi-disciplinary team.

Limitations

- The client must be orientated to time, place, person and at a minimum, be able to maintain attention and concentration to answer simple questions about recent events (past week) to participate in the task. Orientation may be impacted by illness, neurological conditions or injury (dementia, Alzheimer's, delirium, stroke/cerebrovascular accident, acquired brain injury), psychopathology, intellectual impairment, communication problems, pain or drug and/or alcohol abuse. If orientation problems present as an acute onset, cease the task and arrange for urgent medical review e.g. call an ambulance or alert the facility medical team. If the client is unable to complete the task due to problems with orientation, concentration or communication or the orientation questioning results are unclear, liaise with a health profession with expertise in cognition and mood assessment.
- The client (or carer) reports new behaviour/s that are abnormal or strange e.g. acute episodes of confusion, forgetfulness or paranoia. This may be due to a new health condition or exacerbation of a pre-existing health condition e.g. urinary tract infection, hypoglycaemia, transient ischaemic attack or drug induced psychosis. The client may appear unwell, including signs of sweating, pallor, psychomotor agitation, trembling or jaundice. Implement local procedures for emergency/urgent medical review.
- The client (or carer) reports a worsening or acute episode of a known, or suspected, mental illness e.g. depression, anxiety, schizophrenia, bi-polar disorder, psychosis. If the client has a treating psychiatrist, liaise with the treating mental health team. If the client is not under the care of a mental health team, liaise with a health professional with expertise in mental health or local mental health service.
- If the client expresses thoughts of suicidal ideation, self-harm or harm to others, implement local processes to maintain safety, including immediate liaison with a health professional with expertise in mental health to provide suicide risk assessment and management planning.

Safety and quality

Client

- The skill share-trained health professional shall identify and monitor the following risks and precautions that are specifically relevant to this clinical task:
  - for clients with a known or suspected mild cognitive impairment, mood screening may still be conducted. The GDS-15 has been shown to be suitable for use with clients with a Standardised Mini Mental State Examination (SMMSE) score of 10 or more (Conradsson, Rosendahl et al., 2013). If the level of cognitive impairment is unclear, the client should be screened for cognitive impairment prior to performing the task using local screening processes e.g. CTI S-

CP01: Screen for cognitive impairment using a standardised tool and provide basic/bridging intervention.

- if the client has a heightened emotional state due to an acute crisis or significant life event, this will impact self-reported states of emotion and introduce a bias. The client may present with signs of being upset, distressed or agitated. It may not be appropriate to administer a standardised tool at this time. Provide reassurance and determine if the task should be arranged at an alternative time or if the client would benefit from a focused psychological assessment and implement local referral pathways. If the task is to be completed at another time, provide education to the client on accessing support services if required in the interim.
- clients with co-morbidities including chronic diseases may be at greater risk of mood problems and this may skew results. The GDS-15 has been shown to be valid and reliable with healthy, medically ill and mild to cognitively impaired older adults, residing in community, acute care and long-term care settings (Greenburg, 2019). It may be appropriate to adjust the cut off score sensitivity for some client populations including Alzheimer's disease, progressive dementia, Parkinson's disease, stroke, and those in geriatric care (AbilityLab, 2013). Local protocols should be developed to support any changes to the cut off score and may include re-test timeframes or the implementation of additional monitoring or screening requirements. Where local protocols are not available and the score is "borderline", liaise with a health professional with expertise in the task to develop a management plan, including using the tool for monitoring purposes and recommended time periods for re-screening or suitability for referral to local services, including condition-specific services or support groups.
- clients may not directly report being depressed, stressed or anxious. If indications are present, screening using a standardised tool is still indicated and can proceed if the client agrees, as the client may be having difficulty expressing emotions and the tool will assist with assessing the severity of the symptoms.
- the DASS-21 and GDS-15 have been translated into a number of languages. For the latest list of translations refer to the translation pages in the Learning resource required readings.
- the DASS-21 is suitable for screening normal adolescents and adults. The GDS-15 is designed for older adults (65+). Alternative assessments are required for paediatric populations.

Equipment, aids and appliances

- As part of testing, the client will need to respond to verbal questioning. If the client requires glasses, hearing aids or uses communication aids, ensure these are in working order and worn.

Environment

- Testing should be conducted in a quiet location that provides privacy. This includes minimising background noise and distractions e.g. close curtain/door, turn of the radio/TV.

Performance of clinical task

1. Preparation

- Collect or access the relevant recording form (printed or electronic version on ieMR).

2. Introduce task and seek consent

- The health professional checks three forms of client identification: full name, date of birth, **plus one** of the following: hospital unit record (UR) number, Medicare number, or address.
- The health professional introduces the task and seeks informed consent according to the Queensland Health Guide to Informed Decision-making in Health Care, 2nd edition (2017).

3. Positioning

- The client's position during the task should be:
  - sitting comfortably in a supportive chair or bed.
- The health professional's position during the task should be:
  - sitting opposite or beside the client.

4. Task procedure

- The task comprises the following steps:
  1. Determine the client's suitability to undertake a standardised screen for mood using information from the medical chart, subjective history and observation. See Indications and Limitations section and the Guide to history taking for clients with suspected mood problems in the Learning resource.
  2. Select a suitable tool for use. See Table 1 in the Learning resource.
  3. Administer the tool as per the guidelines.
  4. Calculate the total score. If using the DASS-21, this includes using the scoring template and doubling the score as part of finalising calculations. Failure to do this will result in a lower score and incorrect interpretation.
  5. Determine if the client has screened positively for a mood problem and using the information collected, develop a plan to address identified problems. See Learning resource.
  6. Discuss the plan with the client and if relevant the carer, make any adjustments.
  7. Implement the plan including a process for review, if required.

5. Monitoring performance and tolerance during the task

- Common errors and compensation strategies to be monitored and corrected during task include:
  - the mood screening tools (GDS-15 and DASS-21) refer to the client's experience for the prior week. If the client reports symptoms for a time period outside of this range, provide acknowledgement and redirect the client to the recency of the statements i.e. the past week.
  - if the client is self-administering the tool, offer support for any items that they are uncertain of the meaning. For example, dryness of the mouth when the weather has been hot may need explanation to indicate dryness not associated with thirst, discussing the meaning of additional tremors for someone with Parkinson's disease, or where the terms 'downhearted and blue' are not culturally understood, these may need to be replaced with similar descriptive words for example 'sad'.
  - the client may become emotionally labile during the screening process. Pause the task. Provide reassurance that the score will support the identification of suitable services. If

symptoms persist, cease the task and liaise with a health professional with expertise in mood assessment.

  - clients may become distressed, defensive, anxious or hostile whilst undertaking mood screening. This may be due to concerns of being labelled with a mental health condition. Provide reassurance that the screening tool is designed to provide an objective measure of their reported symptoms and assist in understanding their experience. The tool is not a definitive diagnostic measure but will assist in the development of a plan to help manage their symptoms. If the client continues to demonstrate signs of distress, defensiveness or hostility, or withdraws consent, cease the task and liaise with a health professional with expertise in the task.

- Monitor for adverse reactions and implement appropriate mitigation strategies as outlined in the Safety and quality section above.

6. Progression

- Task progression strategies include:
  - as mood problems may develop over time, repeat screening may be required. For example, when the client's health and/or circumstances change, or when new observations are noted. The GDS-15 and DASS-21 refer to the client's experience for the prior week, re-testing within this time period may have limited value/benefit.

7. Document

- Document the outcomes of the task as part of the skill share-trained health professional's entry in the relevant clinical record, consistent with relevant documentation standards and local procedures. For this task, information should include the:
  - indication for undertaking screening for mood problems.
  - name of screening tool used.
  - outcomes/score of the administered screening tool and if using the DASS-21 include descriptors.
  - management plan to address any deficits identified in mood, including provision of education, referral for psychological assessment or mitigating strategies implemented to maintain client safety. Documentation of management implemented includes actions taken if the skill sharing task was ceased due to limitations e.g. identification of suicidal ideation.
- The skill shared task should be identified in the documentation as 'delivered by skill share-trained (insert profession) implementing S-SP01: Screen for mood problems using a standardised tool and provide basic/bridging intervention' or similar wording.

References and supporting documents

- AbilityLab (2013). Rehabilitation Measures Database. Geriatric Depression Scale. Available at: https://www.sralab.org/rehabilitation-measures/geriatric-depression-scale
- Conradsson M, Rosendahl E, Littbrand H, Gustafson Y, Olofsson B, Lovheim H (2013). Usefulness of the Geriatric Depression Scale 15-item version among very old people with and without cognitive impairment. Aging Mental Health 17(5): 638-45. Available at: https://www.ncbi.nlm.nih.gov/pubmed/23339600

- Greenberg S.A (2019). The Geriatric Depression Scale (GDS). The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers College of Nursing. Available at: https://consultgeri.org/try-this/general-assessment/issue-4.pdf
- Queensland Government (2016). Grief counselling and support. Available at: https://www.qld.gov.au/health/support/loss/coping
- Queensland Health (2017). Guide to Informed Decision-making in Health Care (2nd edition). Available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf

Assessment: performance criteria checklist

S-SP01: Screen for mood problems using a standardised tool and provide basic/bridging intervention

Name: **Position:** **Work Unit:**

Performance criteria	Knowledge acquired	Supervised task practice	Competency assessment
	Date and initials of supervising AHP	*Date and initials of supervising AHP*	*Date and initials of supervising AHP*
Demonstrates knowledge of fundamental concepts required to undertake the task through observed performance and the clinical reasoning record.			
Identifies indications and safety considerations for the task and makes appropriate decisions to implement the task, including any risk mitigation strategies, in accordance with the clinical reasoning record.			
Completes preparation for the task including collecting the local recording form and a pen/electronic form.			
Describes the task and seeks informed consent.			
Prepares the environment and positions self and client appropriately to ensure safety and effectiveness of the task, including reflecting on risks and improvements in the clinical reasoning record where relevant.			
Delivers the task effectively and safely as per the CTI procedure in accordance with the Learning Resource. a) Clearly explains and demonstrates the task, checking the client's understanding. b) Determines the client's suitability to undertake standardised screening for mood using information from the medical chart, subjective history and observation. c) Selects a suitable tool for use. d) Administers the tool as per the guidelines. e) Calculates the score. f) Determines if the client has screened positively for a mood problem and using the information collected, develops a suitable plan to address identified problems. g) Discusses the plan with the client and if relevant the carer, making any adjustments. h) Implements the plan including a process for review, if required.			

i) During the task, maintains a safe clinical environment and manages risks appropriately.			
Monitors for performance errors and provides appropriate correction, feedback and/or adapts the task to improve effectiveness, in accordance with the clinical reasoning record.			
Documents in the clinical notes including a reference to the task being delivered by the skill share-trained health professional and the CTI used.			
If relevant, incorporates outcomes from the task into an intervention plan e.g. plan for task progression, interprets findings in relation to care planning, in accordance with the clinical reasoning record.			
Demonstrates appropriate clinical reasoning throughout the task, in accordance with the Learning Resource.			

Comments on the scope of competence for the health professional

The health professional has been trained and assessed as competent to deliver the following mood screening tools:

□ Depression, Anxiety and Stress Scale-21 (DASS-21)

□ Geriatric Depression Scale – short form (GDS-15)

A local health service can elect to add or substitute another standardised mood screening tool. This decision requires appropriate consideration of the risk and training requirements associated with the alternative tool. Additional mood screening tools that the health professional has been trained and assessed as competent to deliver include:

□ _____

□ _____

Comments:

Record of assessment competence:

Assessor name:	Assessor position:	Competence achieved: / /

Scheduled review:

Review date: / /	

S-SP01: Screen for mood problems using a standardised tool and provide basic/bridging intervention

Clinical reasoning record

- The clinical reasoning record can be used:
  - as a training resource, to be completed after each application of the skill shared task (or potential use of the task) in the training period and discussed in the supervision meeting.
  - after training is completed for the purposes of periodic audit of competence.
  - after training is completed in the event of an adverse or sub-optimal outcome from the delivery of the clinical task, to aid reflection and performance review by the lead practitioner.
- The clinical reasoning record should be retained with the clinician's records of training and not be included in the client's clinical documentation.

Date skill shared task delivered: _____

1. Setting and context

- insert concise point/s outlining the setting and situation in which the task was performed, and their impact on the task

2. Client

Presenting condition and history relevant to task

- insert concise point/s on the client's presentation in relation to the task e.g. presenting condition, relevant past history, relevant assessment findings

General care plan

- insert concise point/s on the client's general and profession-specific/allied health care plan e.g. acute inpatient, discharge planned in 2/7

Functional considerations

- insert concise point/s of relevance to the task e.g. current functional status, functional needs in home environment or functional goals. If not relevant to task - omit.

Environmental considerations

- insert concise point/s of relevance to the task e.g. environment set-up/preparation for task, equipment available at home and home environment. If not relevant to task - omit.

Social considerations

- insert concise point/s of relevance to the task e.g. carer considerations, other supports, client's role within family, transport or financial issues impacting care plan. If not relevant to task - omit.

Other considerations

- insert concise point/s of relevance to the task not previously covered. If none - omit.

3. Task indications and precautions considered

Indications and precautions considered

- insert concise point/s on the indications present for the task, and any risks or precautions, and the decision taken to implement/not implement the task including risk management strategies.

4. Outcomes of task

- insert concise point/s on the outcomes of the task including difficulties encountered, unanticipated responses

5. Plan

- insert concise point/s on the plan for further use of the task with this client including progression plan (if relevant)

6. Overall reflection

- insert concise point/s on learnings from the use of the task including indications for further learning or discussion with the lead practitioner

Skill share-trained health professional	**Lead health professional (trainer)**
Name:	Name:
Position:	Position:
Date this case was discussed in supervision:	**/ /**
Outcome of supervision discussion:	e.g. further training, progress to final competency assessment

Screen for mood problems using a standardised tool and provide basic/bridging intervention: Learning resource

Required reading

Depression Anxiety Stress Scales (DASS-21)

- Psychology Foundation of Australia (2018). Depression Anxiety Stress Scales (DASS). Available at: http://www2.psy.unsw.edu.au/dass/

Geriatric Depression Scale – short form (GDS-15)

- AbilityLab (2013). Rehabilitation Measures Database. Geriatric Depression Scale. Available at: https://www.sralab.org/rehabilitation-measures/geriatric-depression-scale
- Aging Clinical Research Centre (ACRC) Stanford University. Geriatric Depression Scale. Available at: https://web.stanford.edu/~yesavage/GDS.html

  NB: this site has access to available translated versions of the GDS-15.
- Greenberg S.A (2019). The Geriatric Depression Scale (GDS). The Hartford Institute for Geriatric Nursing, New York University, Rory Meyers College of Nursing. Available at: https://consultgeri.org/try-this/general-assessment/issue-4.pdf

Example local resources

The following resources have been recommended to support the implementation of this task. The list below are examples of good quality resources.

Client resources for general wellbeing

The local service will determine which resources will be included for use in this task. The resources are provided for information purposes only.

- Beyond Blue (2019). Wellbeing. Available at: https://www.beyondblue.org.au/personal-best/pillar/wellbeing
- Black dog institute (2018). Fact sheets. Available at: https://www.blackdoginstitute.org.au/about-us/publications-and-resources/fact-sheets
- Headspace (2019). For young people. Health & wellbeing. Available at: https://headspace.org.au/young-people/health-and-wellbeing/
- Lifeline (n.d.). Fact sheets. Available at: https://www.lifeline.org.au/get-help/tools/fact-sheets-resources
- MindSpot (n.d.). Fact sheets. Available at: https://mindspot.org.au/fact-sheets

The information and services referenced below relate to Queensland.

- Queensland Government (2019). Mental Health and wellbeing. Available at: https://www.qld.gov.au/health/mental-health
- Queensland Government (2018). 1300 MH CALL: Mental health access line. Available at: https://www.qld.gov.au/health/mental-health/help-lines/1300-mh-call
- Resources and assessment tools (DASS & GDS). (Queensland Health employees only). Available at: https://qheps.health.qld.gov.au/caru/networks/dementia-old/clinician

Specific resources for specific client cohorts

Acquired brain injury

- Queensland Government (2017). Mental Health and ABI. Available at: https://www.health.qld.gov.au/abios/mental-health-and-abi/mental_health

Alcohol and Other Drug Services

- Comorbidity Guidelines (2019). How common is comorbidity and why is it of concern? Available at: https://comorbidityguidelines.org.au/part-a-what-is-comorbidity-and-why-is-it-important/a2-how-common-is-comorbidity-and-why-is-it-of-concern
- Beaufort I.N, De Weert-Van Oene G.H, Buwalda V.A.J, de Leeuw J.R.J, Goudriaan A.E (2017). The Depression, Anxiety and Stress Scale (DASS-21) as a screener for depression in substance use disorder inpatients: a pilot study. European Addiction Research (23):5:260-268. Available at: https://www.karger.com/Article/FullText/485182

Cancer

- Australian Government: Cancer Australia. (2019). Available at: https://canceraustralia.gov.au/affected-cancer/living-cancer/managing-emotional-changes
  - Feelings after cancer
  - Managing emotional changes due to cancer.
- Cancer Council Australia (2013). Emotions and cancer. A guide for people with cancer, their families and friends. Available at: https://www.cancer.org.au/content/about_cancer/ebooks/Emotions%20and%20Cancer%20booklet.pdf
- Pitman A, Suleman S, Hyde N, Hodgkiss A (2018). Depression and anxiety in patients with cancer. The BMJ 361. Available at: https://www.bmj.com/content/361/bmj.k1415

Chronic pain

- Clark M.R (2017). Chronic pain and depression: sorting out types of mood disorders. Practical Pain Management 13(7). Available at: https://www.practicalpainmanagement.com/treatments/chronic-pain-depression-sorting-out-types-mood-disorders
- Hooten W.M (2016). Chronic pain and mental health disorders: shared neural mechanisms, epidemiology, and treatment. Mayo Clinic Proceedings: Symposium on pain. 91(7):955-970. Available at: https://www.mayoclinicproceedings.org/article/S0025-6196(16)30182-3/pdf
- Institute of Medicine (US) Committee on Pain, Disability, and Chronic Illness Behavior; Osterweis M, Kleinman A, Mechanic D, editors. Pain and Disability: Clinical, Behavioral, and Public Policy Perspectives. Washington (DC): National Academies Press (US); 1987. 9, Psychiatric Aspects of Chronic Pain. Available from: https://www.ncbi.nlm.nih.gov/books/NBK219250/

- McWilliams L.A, Cox B.J, Enns M.W (2003). Mood and anxiety disorders associated with chronic pain: an examination in a nationally representative sample. Pain 106(1-2):127-133. Available at: https://www.sciencedirect.com/science/article/pii/S0304395903003014

Older adults

Reading

- Birrer R.B, Vemuri S.P (2004). Depression in later life: a diagnostic and therapeutic challenge. American Family Physician 69(10): 2375-2382. Available at: https://www.aafp.org/afp/2004/0515/p2375.html
- Rodda J, Walker Z, Carter J (2011). Depression in older adults. The BMJ (343:d5219. Available at: https://www.bmj.com/content/343/bmj.d5219
- The Royal Australian College of General Practitioners (2015). Medical care of older persons in residential aged care facilities (4th Ed): Depression (p33-36). Available at: https://www.racgp.org.au/FSDEDEV/media/documents/Clinical%20Resources/Guidelines/Silverbook/Medical-care-of-older-persons-in-residential-aged-care-facilities.pdf
- Victorian State Government (2018). Better Health Channel. Depression and ageing. Available at: https://www.betterhealth.vic.gov.au/health/conditionsandtreatments/depression-and-ageing

Viewing

- Royal College of Psychiatrists (2019). Depression in older adults. Available at: https://www.rcpsych.ac.uk/mental-health/problems-disorders/depression-in-older-adults
- Weill Medical College of Cornell University. Depression Recognition and Assessment in Older Homecare patients. Available at: http://www.geriu.org/uploads/applications/DepressionInHomecare/DinHomecare.html

Examples of local documents that support mood assessment referral pathways

- Leckning B, Ringbauer A, Robinson G, Carey T.A, Hirvonen T, Armstrong G, Westby M, (2019). Guidelines for best practice psychosocial assessment of Aboriginal and Torres Strait Islander people presenting to hospital with self-harm and suicidal thoughts. Menzies School of Research: Darwin. (Queensland Health employees only). Available at: https://www.yammer.com/health.qld.gov.au/#/uploaded_files/142220746752?threadId=291730480955392
- McLean P, Torkington R, Ratsch A (2019). Development, implementation and outcomes of post-stroke mood assessment pathways: implications for social workers. Australian Social Work 72(3): 336-356. Available at: https://www.tandfonline.com/doi/full/10.1080/0312407X.2019.1579350

Guide to history taking for clients with suspected mood problems

- The following information should be obtained from the medical chart, client, carer or other key informant:
  - has the client commenced or changed any medications recently? Is the client experiencing any side effects from their medication? Side effects can cause or exacerbate mood problems. Check the Limitations section. If yes, determine the time-period of onset of symptoms and medication change/commencement, and liaise with the prescriber as part of the management plan.

- does the client have a history of intellectual impairment, mental illness, neurological injury (stroke/cerebrovascular accident, acquired brain injury), communication problems, pain or drug and/or alcohol abuse? If yes, review the Limitation section.
- does the client have any cognitive problems including memory, attention and judgement problems? See the Limitations section and the Safety and quality section.
- has the client previously undertaken mood screening? If yes, when? See required readings to determine validity of re-testing.
- is there a known history of depression, memory problems or difficulty concentrating, including dementia, Alzheimer's disease or intellectual impairment? A family history may indicate a hereditary predisposition for depression. Review the Limitations section.
- is the client living alone? If yes, does the client have adequate family or social networks? Identify the supports that exist including type and frequency. If unable to identify adequate family or social networks, liaise with a health professional with expertise in the task as part of developing the management plan. Clients who screen for a mood problem and live alone may require additional supports.
- has the client recently experienced the death or change in circumstances of a partner, family member or friend? When did this occur? Mood problems for greater than two months associated with grief and loss indicates a need for bereavement counselling services and should be included in the management plan (Queensland Government, 2016). Check the Safety and quality section and the Limitations section.
- does the client actively engage in any hobbies or interests? If yes, has this changed? Determine the reason e.g. no longer has transport, changes in health status including pain or injury. Clients who are depressed are less likely to engage with hobbies and interests.
- does the client engage in community activities such as shopping, sport or church? If yes, has this changed? Determine the reason e.g. no longer has transport, a change in health status including pain or injury. Clients who are depressed are less likely to engage with their regular community activities.
- is the client experiencing, or had anyone else comment on them having, mood problems? It can be useful to prompt with examples including changes in:
    - appetite or lost/gained weight or experiencing a change in interest in food (increased or decreased).
    - sleep changes including waking up frequently, difficulty getting to sleep or sleeping more than usual.
    - usual activities that they are interested in or bring them enjoyment.
    - mood including feeling flat, low, down, nervous or anxious.
    - physical symptoms such as nausea, high heart rate or breathing rate, trembling and/or sweating with triggers that do not settle quickly/easily.

    If yes, determine the time period of onset e.g. days, weeks and years. If presentation is acute and of sudden onset, refer to the Limitations section.

    If the client answers 'no' to questions on the signs and symptoms above but there are indications apparent, progress the implementation of this skill share task. Discuss with the client the rationale for screening including obtaining a baseline measure for comparison.

Table 1 supports decision-making on use and selection of a mood screening tool.

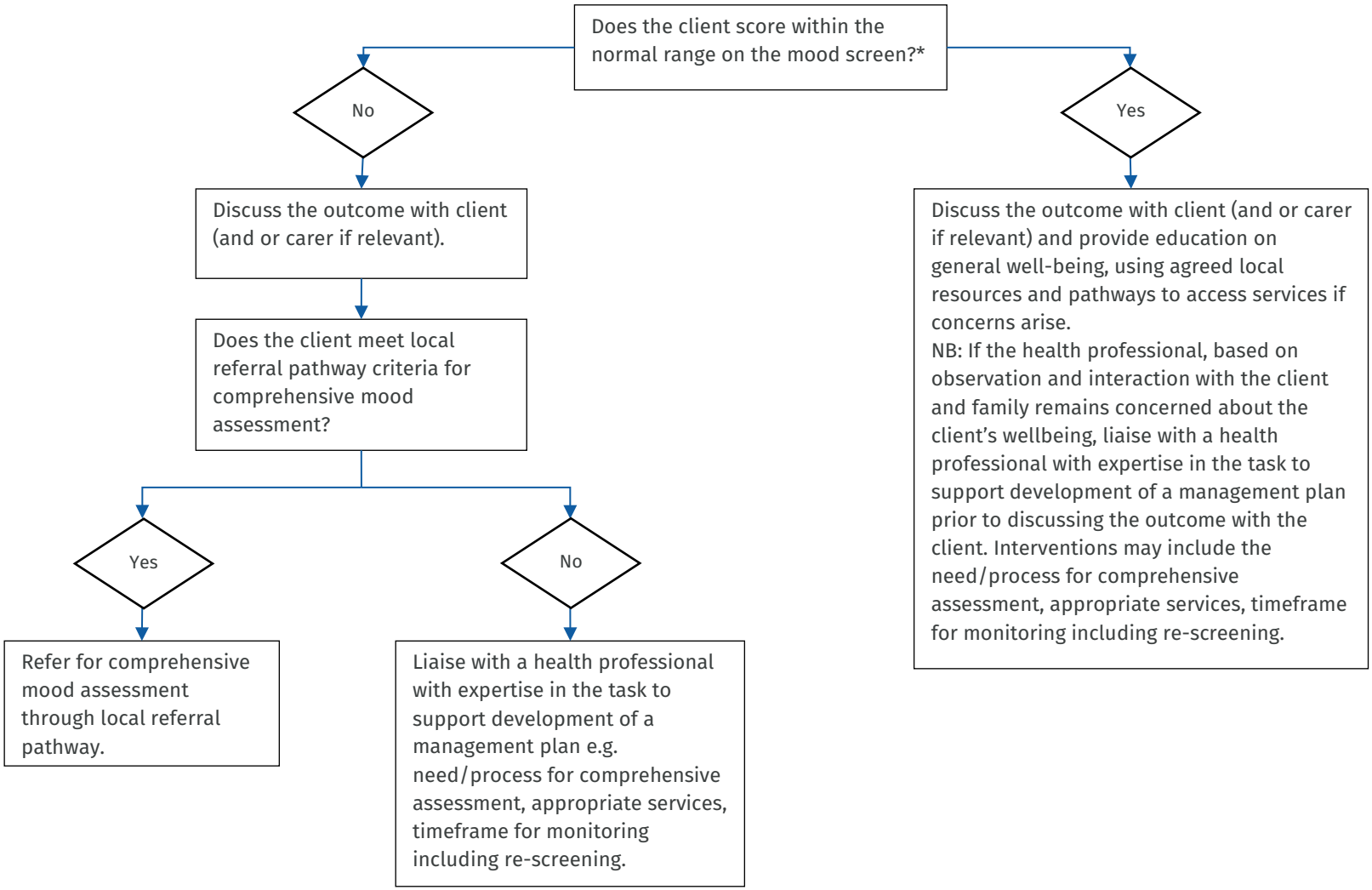
Table 1: A comparison table between mood screening tools – DASS-21 and GDS-15

Criteria	DASS - 21	GDS – 15
Client age	Suitable for 14 years of age and above	Suitable for clients 65 years old and above
Client groups		Has been used by people who are physically ill and with mild to moderate dementia who have short attention spans and/or feel easily fatigued, located in community, acute care and long-term care settings.
Other languages	Available at: http://www2.psy.unsw.edu.au/dass/translations.htm	Available at: https://web.stanford.edu/~yesavage/GDS.html
Number of questions	21	15
Time to complete	3 minutes	5-7 minutes
Focus of screen	Depression, stress and anxiety	Depression and suicidal intent
Recall period	Past week	Past week
Norm cut off score	Detailed information about DASS norms and interpretation is available in the DASS manual. Local services may have agreed cut-off scores to guide care management planning based on published literature for similar client groups represented in the local service model. These should be documented in service model documents.	A score of 5 or greater points is suggestive of depression and warrants follow up by health professionals with expertise in assessment and management of depression. A score of 10 or greater points is highly likely to be indicative of depression. Implement local processes for appropriate actions e.g. referral to the relevant medical officer regarding the results (i.e. geriatrician, GP, medical officer) in a timely manner (i.e. within 24hrs of administration of screen) to engage appropriate investigation and management, and notification of a care co-ordinator (if relevant).

Interpreting the mood screen

The purpose of mood screening is to support clinical decision making, including the need for a comprehensive mood assessment. Figure 1 is a decision support tool that can assist the health professional to develop a plan following mood screening using the GDS-15 or DASS.

Figure 1: Decision tool to support the outcome of mood screening using the DASS-21 and/or GDS-15.



* refer to Table 1